STATE OF MAINE
BOARD OF NURSING
158 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0158

JOHN ELIAS BALDACCI
GOVERNOR

MYRA A. BROADWAY, J.D., M.S., R.N.
EXECUTIVE DIRECTOR

Application for Approval of a Supervising Relationship with a Licensed Physician or Nurse Practitioner

A certified nurse practitioner who qualifies as an advanced practice registered nurse must practice, for at least 24 months, under the supervision of a licensed physician or a *supervising nurse practitioner or must be employed by a clinic or hospital that has a medical director who is a licensed physician. The certified nurse practitioner shall submit written evidence to the board upon completion of the required clinical experience (32 MRSA, Section 2102, 2-A).

Instructions

1. **Before the new nurse practitioner (NP) begins employment**, the NP must register a supervising relationship with the Board as part of the authorization to practice process.

2. **When modifying a supervisory relationship,** the NP must register the change on the provided form within 15 days of beginning employment. A $50.00 late registration fee will be assessed if this form is not filed within 15 days of beginning employment.

3. **In the absence of** the Primary Supervising Physician or Nurse Practitioner, a Secondary Supervising Physician or Nurse Practitioner must be designated. This information must be included on the application.

4. **When a supervisory relationship is terminated,** the NP must notify the Board. The NP may use this form.

5. **At the end of the required twenty four months of supervision**, the NP must submit documentation of completion of the required clinical experience.

*The nurse practitioner must submit documentation to the Board of the following:

1. Completed 24 months of supervised practice, and
2. Practiced as an advanced practice registered nurse for a minimum of 5 years in the same specialty, and
3. Worked in a clinical health care field for a minimum of 10 years.

PHONE: (207) 287-1133
OFFICES LOCATED AT: 161 CAPITOL ST., AUGUSTA, ME
http://www.maine.gov/boardofnursing/
FAX: (207) 287-1149

Please Type or Print All Information Clearly

Name of Nurse Practitioner Applicant _____ **Maine License #** _____

Primary Supervising Physician/Nurse Practitioner _____ **Maine License #** _____

Secondary Supervising Physician/ Nurse Practitioner _____ **Maine License #** _____

Secondary Supervising Physician/ Nurse Practitioner _____ **Maine License #** _____

(attach a separate page if more space needed)

1. Name(s)/Address(s) of Practice Setting(s)

_____
_____
_____
Tel: _____
Start date: _____ **Hours per week:** _____

Practice Type
(Please circle one)

Office Practice
Clinic
Hospital
Other (Explain)_____
_____

2. Name(s)/Address(s) of Practice Setting(s)

_____
_____
_____
Tel: _____
Start date: _____ **Hours per week:** _____

Practice Type
(Please circle one)

Office Practice
Clinic
Hospital
Other (Explain)_____
_____

3. Name(s)/Address(s) of Practice Setting(s)

_____
_____
_____
Tel: _____
Start date: _____ **Hours per week:** _____
(attach a separate page if more space needed)

Practice Type
(Please circle one)

Office Practice
Clinic
Hospital
Other (Explain)_____
_____

Please check the appropriate box: **Fee**
Attach letter of supervision signed and dated by a licensed physician or nurse practitioner in the same practice category.

( ) First time registration with a Primary Supervising Physician or Nurse Practitioner $50.00

( ) Change of Primary Supervising Physician or Nurse Practitioner Relationship $50.00

( ) Registration of Supervisory Relationships for multiple work sites $25.00

You must submit a check or money order payable to the Treasurer of the State of Maine or attach a separate page with the following credit card information pertaining to your Visa/Mastercard (credit card number, expiration date, billing address, and signature).

( ) Termination of a Primary Supervising Relationship **during the twenty four month** supervisory period.
Please attach a letter signed by the Primary Supervising Physician or Nurse Practitioner indicating the time frame (beginning and ending dates) and Hours per week or total hours of supervision.

Name of Primary Supervising Physician or Nurse Practitioner:
_____
Effective Date:_____
Reason for Termination:_____
_____
_____
_____
_____
_____

( ) Completion of the required twenty four month supervision requirement.
Please attach a letter signed by the Primary Supervising Physician or Nurse Practitioner indicating the time frame (beginning and ending dates) and Hours per week or total hours of supervision.

_____ _____
Signature of Applicant **Date**